Chapter 2
Teachers' Choice Health Plan (TCHP)

TCHP – GENERAL INFORMATION

Overview

TCHP is a traditional indemnity plan which offers a comprehensive range of benefits. Under TCHP, plan participants choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using Preferred Provider Organization (PPO) hospitals and physicians, network pharmacies for prescription drugs and mental health/substance abuse providers authorized by the mental health/substance abuse plan administrator.

Plan Components

- **TCHP is comprised of three independent components:**
  - Medical.
  - Prescription Drugs.
  - Mental Health/Substance Abuse Treatment Services.

It is not necessary to satisfy the plan year deductible in order to start receiving benefits for prescription drugs or mental health/substance abuse services. These programs are not subject to out-of-pocket maximums. However, these programs are applied towards the lifetime maximums.

Each of these three components is discussed separately in this chapter. Please note that each component has its own plan administrator. See Chapter 3, Section entitled Plan Administrators.

Plan Features

Plan Participant Responsibilities

- **The Plan Participant is always responsible for:**
  - Any amount required to meet **plan year deductibles, special deductibles** and **coinsurance amounts**.
  - Any amount over **Usual and Customary (U&C)**.
  - Any penalties for failure to comply with the **Notification Requirements.**
  - Any charges not covered by the Plan or not determined by the TCHP Plan Administrator to be **medically necessary** services.

Plan Year Deductible

The plan year deductible must first be satisfied before benefits begin. This deductible requirement applies to all services unless otherwise noted. The plan year deductible applies toward satisfying the out-of-pocket maximums as well.

Each covered person has a plan year deductible of $250 that must be satisfied. Each plan year begins on July 1.

Special Deductibles

In addition to the plan year deductible, plan participants must pay a special deductible of **$250** for each emergency room visit that does not result in a hospital admission. A special deductible of **$250** will apply for each admission to a non-PPO hospital. The deductible is waived for admission to a PPO hospital or for medically necessary transfers.

These special deductibles accumulate toward the annual out-of-pocket maximums, but do not satisfy the plan year deductible. **See page 37 for details.**

Coinsurance

After the plan deductible has been met, the Plan generally pays most of the cost of services or supplies; but plan participants must pay a percentage (called coinsurance) on most bills. Plan participants may be responsible for applicable co-insurance of eligible professional charges for a physician's office visit.

Plan Year Maximum Out-of-Pocket Expenses

There are two separate out-of-pocket maximums: a general and a non-PPO. Coinsurance and deductibles count toward one or the other, but not toward both. See the Section entitled Medical Benefits Summary in this chapter.

General Out-of-Pocket Maximum – The amounts paid toward deductibles and coinsurance, except for charges related to a non-PPO hospital/facility, accumulate toward satisfying the out-of-pocket maximum.

After the general out-of-pocket maximum has been met, coinsurance amounts are no longer required and the Plan pays 100% of eligible charges for the remainder of the plan year.

Non-PPO Out-of-Pocket Maximum – The amounts paid toward deductibles and coinsurance at a non-PPO hospital/facility accumulate toward satisfying the non-PPO out-of-pocket maximum.

Eligible Charges

- **TCHP provides benefits for eligible charges only. Eligible charges for those covered services and supplies which are:**
  - Medically necessary.
  - Based on Usual and Customary (U&C).

Medical Necessity

- **TCHP covers charges for services and supplies that are medically necessary. Medically necessary services or supplies are those which are:**
  - Provided by a hospital, prescribed by a physician, or other provider and are required to identify and/or treat an illness or injury.
  - Consistent with the symptoms or diagnosis and treatment of the condition (including pregnancy), disease, ailment or accidental injury.
  - Generally accepted in medical practice as necessary and meeting the standards for good medical practice for the diagnosis or treatment of the patient's condition.
  - The most appropriate supply or level of service which can be safely provided to the patient.
  - Not solely for the convenience of the patient, physician, hospital or another provider.
  - Repeated only as indicated as medically appropriate.
  - When specifically applied to a confinement, it further means that the patient's medical symptoms, condition, diagnosis or treatment cannot be safely provided as outpatient.
  - Not redundant when combined with other treatment being rendered.

For determination of medically necessary services or supplies, contact the appropriate plan administrator in writing to request a pre-determination.

Usual and Customary (U&C)

U&C is an amount determined by the Medical Plan Administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition. U&C applies to professional fees and some other services.

If a charge exceeds U&C, the plan participant is responsible for the portion of the expense that is above U&C. Amounts in excess of U&C are not eligible and are not applicable to plan year deductible or out-of-pocket maximum.

IMPORTANT: The percentage of the claim that will be paid is always based on U&C or the actual charge made by the provider, whichever is less.

Preferred Provider Organization (PPO) Hospital Networks

The Hospital PPO Networks include hospitals nationwide and throughout Illinois. The network is subject to change. Refer to the annual Benefit Choice Options Booklet for information on network PPO hospitals.

PPO hospitals provide quality care at reduced rates, which can result in significant savings to plan participants. The benefit level for inpatient services and outpatient surgery when utilizing a PPO hospital is 80% of the negotiated rate, rather than 60% of U&C. In addition, there is no admission deductible for inpatient care rendered at a PPO hospital.

A 60% benefit level will apply if a plan participant utilizes a non-PPO hospital when a TCHP PPO hospital is located within the same travel distance. Although any hospital may be used for inpatient services and outpatient surgery, the enhanced benefit of 80% is received only when utilizing a PPO network hospital.

Should the negotiated PPO rate exceed the actual charges, contact CMS/Group Insurance Division in writing to request a review.

Exceptions to the PPO Hospital Network

Any hospital may be used for inpatient or outpatient services, but enhanced benefits are received at a PPO network hospital.

Exceptions to the non-PPO benefit of 60% are evaluated by the Notification Administrator, upon request, when emergency or specialized care is required but not available at the TCHP PPO hospital. If an exception is granted, the benefit is 70% of U&C. If an exception is not granted, the non-PPO 60% benefit will apply.

If a plan participant chooses to travel more than 25 miles and a TCHP PPO hospital is available within the same travel distance, a TCHP PPO hospital must be used or the 60% benefit will apply.

Medical Case Management

TCHP has a benefit called the Medical Case Management (MCM) Program. MCM is designed to assist the plan participant requiring complex care in times of serious or prolonged illness.

If a plan participant is confronted with such illness, an MCM case manager will help find appropriate treatment to ensure maximum benefits under the Plan. Involvement in MCM has proven to enhance benefits based on an evaluation of the individual's needs. MCM is part of the benefits under TCHP. There is no cost to the plan participant for this service.

The referral to the MCM Program is made through either the MCM Administrator, the Medical Plan Administrator or by request from a plan participant. The MCM case manager serves as a liaison and facilitator between the patient, family, physician and health care facility. This case manager is a Registered Nurse or other health care professional with extensive clinical background. The MCM case manager can effectively minimize the fragmentation of care so often encountered within the health care delivery system in response to complex cases.

Upon completing the MCM review, the MCM case manager will make a recommendation regarding the treatment setting, intensity of services and appropriate alternatives of care. **Refusal to participate in the MCM Program will result in a reduction or denial of benefits available under the Plan for treatment of the illness for which the plan participant was referred to MCM.**

To reach the MCM Administrator, call the toll-free number listed in Chapter 3, Section entitled Plan Administrators.

Coordination of Benefits (COB)

If TCHP is primary, benefits will be paid without regard to the other plan's benefits.

- **If the other plan is primary, benefits under the plan will be determined in the following manner:**
  - TCHP will first determine what would have been paid in the absence of any other coverage, subject to applicable deductibles and coinsurance.
  - If a balance due remains after the primary carrier has paid, TCHP will pay that balance *up to* the maximum amount calculated above.

Coordinating Medical Coverage with Medicare

Individuals may qualify for Medicare in a number of ways including age, disability and End-Stage Renal Disease. The issue of whether Medicare pays first, referred to as the primary payer, depends on the employment status of the Member and the reason for receiving Medicare.

When Medicare is primary, TCHP coordinates with Medicare. The TCHP becomes primary for eligible services or supplies not covered by Medicare, or after Medicare benefits have been exhausted. See Notification Requirements in this section.

Part A – Hospital Insurance

- **After Medicare Part A pays, TCHP pays:**
  - All but $50 of the Medicare Part A deductible.
  - Medicare Part A coinsurance.
  - Hospital and Skilled Extended Care Facility stays beyond the maximum days allowed under Medicare, provided that the care satisfies the TCHP criteria of medical necessity and skilled care.

NOTE: All Medicare lifetime reserve days must be used before TCHP will become primary payer.

Part B Medical Insurance

- **After Medicare Part B pays, TCHP pays:**
  - All of the Medicare Part B deductible.
  - The Medicare Part B coinsurance in full.
  - If the provider accepts Medicare assignment, TCHP pays the 20% of approved charges which Medicare does not cover. If the provider does not accept Medicare assignment, TCHP pays all amounts Medicare does not cover, up to the maximum limiting charges set by Medicare.
  - There are limitations on coverage under TCHP if the plan participant does not purchase Medicare Part B coverage.
- **Services and supplies not covered by Medicare:**
  - TCHP pays standard benefits for services and supplies if they meet benefit criteria and would normally be covered if the plan participant does not have Medicare (annual TCHP deductible applies).

Medicare Crossover - Part B Only

Medicare will automatically and electronically forward processed Part B claim(s) to the Medical Plan Administrator. This is known as "Medicare Crossover." The plan participant must provide the Medicare Individual Claim Number (ICN) to the Medical Plan Administrator. Once the ICN is received, the Medical Plan Administrator can receive claim(s) determination information directly from Medicare, and then process Medicare Part B claims according to plan provisions.

Medicare Crossover applies to Part B claims only. Part A claims must continue to be submitted with the Medicare Explanation of Benefits to the Medical Plan Administrator.

IMPORTANT: Questions regarding Medicare Crossover should be directed to the Medical Plan Administrator. Questions regarding eligibility and enrollment for Medicare should be directed to the Social Security Administration.

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of an upcoming admission to a facility such as a hospital or extended care facility or for other services, such as mental health or specified outpatient procedures. Notification is the plan participant's responsibility and is a method to avoid penalties and maximize benefits.

Notification is required for all plan participants including those who may no longer have benefits available from other primary payer insurance or Medicare. Failure to notify the Plan within the required time limits will result in a $1,000 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

Notification is the plan participant's responsibility. Whenever possible, make the initial telephone call to the Notification Administrator, rather than relying on someone else to do this.

- **The Notification Administrator will need the following information:**
  - Patient's name, address and date of birth.
  - Member's name, address and Social Security number.
  - Date of admission, if known, or expected due date of maternity admission.
  - Diagnosis or procedure.
  - Physician's name, address and telephone number (including area code).
  - Hospital or extended care facility name, address and telephone number (including area code).

A "reference number" will be assigned and should be maintained in the plan participant's records. This number serves as a resource should there be any questions regarding notification. The Notification Administrator maintains detailed records on every call when the plan participant's enrollment status is verified.

After notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information, evaluate the setting and anticipated initial length of stay for medical appropriateness, and determine whether a second opinion is required.

- **Notification is required for the following:**
  - **Elective Surgical or Non-Emergency Admission** - At least seven days before admission, call the Notification Administrator.
  - **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. **Notification of a maternity admission is not automatic enrollment of the newborn.** Contact TRS to enroll the newborn.
  - **Skilled Nursing Facility, Extended Care Facility or Nursing Home Admission** - At least seven days before admission, call the Notification Administrator. A review of the care being rendered will be conducted to determine if the services are skilled in nature.
  - **Emergency or Urgent Admission** - The plan participant or physician must contact the Notification Administrator within two business days after the admission.
  - **Outpatient Procedures** - It is necessary to call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), allergy testing, colonoscopy and endoscopy services.
  - **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should provide notification at the

first indication that a transplant may be necessary. **Benefits are available through the Transplant Preferred Provider Organization (TPPO) Network and must be authorized by the Notification Administrator.**

- **Notification is not:**
  - **A final determination of medical necessity -** Health conditions and need for treatment can change quickly. If the Notification Administrator should determine that the stay is no longer medically necessary and not eligible for coverage, the physician will be informed immediately. The plan participant will also receive written confirmation of this determination.
  - **A guarantee of benefits** - Regardless of notification of a procedure or admission, if the plan participant is ineligible for coverage on the date services were rendered or if the charges were ineligible there will be no benefits payment.
  - **Enrollment of a newborn for coverage** Contact TRS to enroll a newborn within 31 days of birth. **Notification of a maternity admission does not mean the newborn is automatically enrolled.**

NOTE: For notification procedures and time limits for mental health/substance abuse services, see Chapter 2, Section entitled Mental Health/Substance Abuse.

To call the Notification Administrator, see Chapter 3, Section entitled Plan Administrators. The toll-free number is also printed on your identification card and in the annual Benefit Choice Options Booklet. You can call seven days a week, 24 hours a day.

Pre-Determination of Benefits

Pre-determination is a method to ensure that medical services will meet medical criteria and be eligible for benefit coverage.

The plan participant's physician must submit written detailed medical information to the Medical Plan Administrator. For questions regarding a pre-determination of benefits, contact the Medical Plan Administrator.

TCHP – MEDICAL BENEFITS SUMMARY

Plan Year Maximums and Deductibles

The benefits described in this summary represent the major areas of coverage under TCHP. Updated information for each plan year will appear in the annual Benefit Choice Options Booklet. The plan year is July 1 through June 30 of the following year.	
Lifetime Maximum	$2 million
Plan Year Deductible	The plan year deductible is $250 for each covered person.
Special Deductibles* ***These are in addition to the plan year deductible.**	Each emergency room visit $250 Non-PPO hospital admission $250 Transplant deductible $100 Note: There is no special deductible for admission to a PPO hospital

Out-of-Pocket Maximums

There are two separate out-of-pocket maximums: a general and a non-PPO. Coinsurance and deductibles listed below count toward one or the other, but not toward both.

General: $800 per individual	**Non-PPO: $4,000 per individual**
Plan year deductible Professional and Physician Coinsurance PPO Facility Coinsurance (20%) Transplant Deductible ($100) Transplant Inpatient and Outpatient Coinsurance (20%) Standard* Hospital Coinsurance (30%) Standard* Hospital Admission Deductible ($250) All Emergency Room Deductibles ($250) Emergency Room Coinsurance (20%) ***When the Notification Administrator grants an exception for a non-PPO admission, or when the plan participant does not reside within 25 miles of a TCHP PPO hospital.**	Non-PPO Hospital Deductible ($250) Non-PPO Inpatient Coinsurance (40%) Non-PPO Outpatient Facility Coinsurance (40%)

The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits or copayments.
- Mental Health/Substance Abuse benefits, coinsurance or copayments.
- Notification penalties.
- Ineligible charges (amounts over U&C and charges for non-covered services).
- The portion ($50) of the Medicare Part A deductible the plan participant is responsible to pay.

Most Commonly Utilized Benefits Under TCHP

Enhanced benefits may be available by utilizing PPO network providers.

Allergy Injections

- 80% of U&C for injections, provided the person has had recognized allergy testing to determine hypersensitivity and the need to be desensitized.
- Allergy testing is paid at 100% of U&C.

Ambulance

- 80% of U&C for transportation charges:
  - To nearest hospital/facility for emergency medically necessary services for a patient whose condition (as determined by the Medical Plan Administrator) warrants such service.
- Common Reasons for Transportation Services:
  - From the site of the disabling illness, injury, accident or trauma to the nearest hospital qualified to provide treatment (includes air ambulance when medically necessary).
  - From a remote area, by air or land, (inside or outside the United States) to the nearest hospital qualified to provide emergency medical treatment.
  - From a facility which is not equipped to treat the patient's specific injury, trauma or illness to the nearest hospital equipped to treat the injury, trauma or illness.
- Transportation exclusions include, but are not limited to:
  - Transportation that is not medically necessary.
  - Transportation between health care facilities for preference or convenience.
  - Transportation of patient for office or other outpatient visit.
  - Transportation of patients who have no other available means of transportation.

Blood/Blood Plasma

- 80% of charges for blood and blood plasma in excess of the first 3 pints in a plan year.

Breast Implantation Removal and Reimplantation

- Coverage for removal or implantation only when medically necessary and not cosmetic in nature.
- Coverage for reimplantation only when initial implant was medically necessary.

Breast Reconstruction Following Mastectomy

- The Plan provides coverage, subject to and consistent with all other plan provisions for services following a mastectomy, including:
  - Reconstruction of the breast (including implant) on which the mastectomy was performed.
  - Surgery and reconstruction on the other breast (including implants) to produce a symmetrical appearance.
  - Prosthesis and treatment for any physical complications at any stage of mastectomy, including post-surgical lymphedema (swelling associated with the removal of lymph nodes) rendered by a provider covered under the Plan.

Cardiac Rehabilitation

- 80% of U&C for Phase I and Phase II, when ordered by a physician.
- Medical necessity must be determined if cardiac rehabilitation is to be considered a covered expense, and services must be provided in a medical facility approved by the Medical Plan Administrator.

Chemotherapy

- 80% of U&C when ordered by a physician.

Charges for infusion catheters to administer the drugs/agents are considered a surgical procedure and paid separately. For chemotherapy received in the home, see Home Infusion Therapy.

Chiropractic Services

- 80% of U&C.
- Eligible charges for medically necessary manipulation and therapeutic modalities for acute illness or injury are covered. Coverage ends once medical documentation indicates that maximum medical improvement has been achieved and treatment is primarily for maintenance.

Christian Science Practitioner

- 80% of charges for the services of:
  - Christian Science Practitioner (see Glossary).
  - Christian Science Nurse (see Glossary).

Circumcision

- 80% of U&C for professional services.
- Charges for circumcision are considered to be covered expenses, when billed as a separate claim for the newborn, if performed within the first thirty (30) days following birth and if the newborn is enrolled in the Plan.
- Charges for circumcision performed beyond the 30-day time frame are considered to be covered expenses only when medical necessity is documented.

Dental Services

- Accidental Injury:
  - 80% of U&C for professional services necessary as a result of an accidental injury to sound natural teeth caused by an external force. Care must be rendered within 3 months of original accidental injury. The appropriate facility benefit applies. The benefit will be limited to the most cost effective treatment available as determined by the Medical Plan Administrator.
- Inpatient Room and Board:
  - 80% of established U&C for semi-private room and board only for medically necessary hospital admissions to perform dental services (nonaccidental) only when a medical condition such as heart disease or hemophilia exists. **Professional services are not covered under the medical indemnity plan.**
- Dental exclusions include, but are not limited to:
  - Services and appliances related to the diagnosis or treatment of Temporomandibular Joint Disorder or Syndrome (TMJ) and other myofunctional disorders.
  - Internal accidental injury to the mouth caused by biting on a foreign object.
  - Outpatient services for routine dental care.

Diabetic Coverage

- For Dietitian Services and Consultation:
  - 80% of U&C when diagnosed with diabetes. No coverage unless ordered in conjunction with a diagnosis of diabetes.
- For routine foot care by a physician:
  - 80% of U&C when diagnosed with diabetes.
- For insulin pumps and related supplies:
  - 80% of U&C.

Dialysis – Hemodialysis and Peritoneal

- 80% of U&C.

Durable Medical Equipment

- Short-term Rental:
  - 80% of U&C up to the purchase price for items that temporarily assist an impaired organ or body part during recovery. Some examples are canes, crutches and walkers.
- Purchase:
  - 80% of U&C to purchase the equipment. Equipment should be purchased only if it is expected that the rental costs will exceed the purchase price.
- Durable medical equipment exclusions include, but are not limited to:
  - Repairs or replacements due to negligence or loss of the item.
  - Newer or more efficient models.
  - Items viewed as convenience items such as exercise equipment and non-hospital type adjustable beds.
  - Environmental items such as air conditioners, humidifiers, dehumidifiers or purifiers.
  - For specific equipment coverage and medical necessity requirements, contact the Medical Plan Administrator.
  - Similar or redundant equipment for patient convenience.

NOTE: See Prosthetic Appliances for permanent replacement of a body part.

Emergency Services

Emergency services are those services provided to alleviate severe pain or for immediate diagnosis and/or treatment of conditions or injuries such that in the opinion of a prudent layperson might result in permanent disability or death if not treated immedi-

ately. **The facility in which emergency treatment is rendered determines the benefit level, regardless of the type of emergency facilities available.**

- Emergency Room:
  - 80% of U&C after $250 special emergency room deductible; this deductible applies to each visit to an emergency room which does not result in an inpatient admission.
- Physician's Office:
  - 100% of U&C; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Non-emergency medically necessary care considered at 80% of U&C.
- Urgent Care or Similar Facility:
  - 100% of U&C; no special emergency room deductible applies. Treatment must be rendered within 72 hours of an injury or illness and meet the definition of emergency services presented above. Non-emergency medically necessary care considered at 80% of U&C (see Urgent Care Services in this section).

Family Planning

- Tubal Ligation:
  - Coverage is extended as in any other condition.
- Vasectomy:
  - Coverage is extended as in any other condition.
- Family planning exclusions include, but are not limited to:
  - Charges for services relating to the reversal of sterilization.
  - Any drug or device prescribed or used for the purpose of contraception.

Foot Orthotics

- 80% of U&C.
- Subject to medical necessity, and ordered by a physician.
- Must be custom molded or fitted to the foot.

Hearing Exams

- 80% of U&C for professional fees for the hearing exam associated with the care and treatment of an injury or an illness.
- Hearing aids and associated costs, including the exam and evaluation for the purpose of screening and obtaining a hearing aid, are not covered.

Home Health Care Services –

See Skilled Nursing Care

Home Infusion Therapy

- 80% of U&C.
- Medical necessity must be determined by the MCM Administrator in order for therapy to be considered a covered expense.
- Home infusion therapy must be under the supervision of a physician.
- Covered expenses include, but are not limited to:
  - Medication and intravenous solution.
  - Equipment rental and supplies such as infusion sets, syringes and heparin.

Hospice

- 80% of U&C. Written documentation of terminal condition (i.e., life expectancy of six months or less) is required from the attending physician.
- Must be approved by the plan administrator as meeting established standards including any legal licensing requirements.

Hospital Services

- Inpatient:
  - 80% of negotiated PPO hospital rate if using a PPO hospital.
  - 70% of U&C if residence is not within 25 miles of a TCHP PPO hospital.
  - 60% of U&C if residence is within 25 miles of a TCHP PPO hospital but plan participant elects to use a non-PPO hospital instead.
  - If residence is within 25 miles of a TCHP PPO hospital, but emergency or specialized care is required which is not available at the TCHP PPO hospital, an exception to the non-PPO rate of 60% may be requested. Upon request, the Notification Administrator will evaluate the case and, when appropriate, authorize an 70% of U&C benefit at a non-PPO hospital. Otherwise, 60% of U&C will apply if the plan participant chooses to travel more than 25 miles and a TCHP PPO hospital is available within the same travel distance.

- Inpatient hospitalization exclusions include, but are not limited to:
  - Holding charges (charges for days when the bed is not occupied by the patient).
  - Private room charges in excess of the established semi-private room and board rate, regardless of any medical necessity such as isolation.
  - Incremental nursing charges if billed separately. These charges are added to and capped at the established rate for room and board charges.
  - Personal convenience items such as guest meals, television rental, admission kits and telephone charges.
  - Services not related to or necessary for the care and treatment of an illness or injury.

- Outpatient:
  - Surgery
    - 80% of negotiated PPO hospital rate if performed at a PPO hospital.
    - 70% of U&C if performed at a non-PPO hospital, if an exception to non-PPO benefits is granted by the Notification Administrator.
    - 60% of U&C if performed at a non-PPO hospital.
    - 80% of U&C if performed at an ambulatory surgical treatment center which is licensed by the Illinois Department of Public Health, or the equivalent agency in other states, to perform outpatient surgery.
    - **Surgical facility exclusions include, but are not limited to:**

      Facility charges for a surgery performed in or billed by a physician's office or clinic; unless specific state ambulatory surgical treatment center licensing requirements are met.

      Facility charges for a surgery or procedure which is not covered.
  - Other services such as non-emergency services:
    - 80% of negotiated PPO hospital rate if performed at a PPO hospital. The plan participant's coinsurance applies to the general out-of-pocket maximum.
    - 70% of U&C if the plan participant's residence is not within 25 miles of a TCHP PPO hospital. The plan participant's coinsurance applies to the general out-of-pocket maximum.
    - 60% of U&C if the plan participant's residence is within 25 miles of a TCHP PPO hospital and participant elects to use a non-PPO hospital. The plan participant's coinsurance applies to the non-PPO out-of-pocket maximum.

NOTE: Failure to provide appropriate notification will result in a $1,000 penalty and no coverage for services not deemed to be medically necessary. See Notification Requirements in Chapter 2, Section entitled TCHP General Information.

Infertility Treatment

Benefits are provided for the diagnosis and treatment of infertility. **Infertility is defined as the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.**

- Pre-determination of Benefits:
  - A written pre-determination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment to ensure maximum benefits. Documentation required from the physician includes the patient's reproductive history including test results, information pertaining to conservative attempts to achieve pregnancy, and the proposed plan of treatment with CPT codes.
- Infertility Benefits:
  - Coverage is provided only if the plan participant has been unable to obtain or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatment for which coverage is available under this Plan.
  - Coverage for Assisted Reproductive Procedures include, but are not limited to:
    - Artificial Insemination, Invitro Fertilization (IVF) and similar procedures which include but are not limited to: Gamete Intrafallopian Tube Transfer (GIFT), Low Tube Ovum Transfer (TET) and Uterine Embryo Lavage.

- A maximum of three (3) artificial insemination procedures per menstrual cycle for a total of eight (8) cycles per lifetime.
- A maximum of four (4) procedures per lifetime for any of the following:
  - Invitro Fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intrafallopian Tube Transfer (ZIFT) and other similar procedures.
- Eligible medical costs associated with sperm or egg donation by a person covered under the Plan may include, but are not limited to:
  - Monitoring the cycle of a donor, and retrieval of an egg for the purpose of donating to a covered individual.

- Benefit Level:
  - The appropriate benefit level will apply (i.e., physician charges are covered at 80% of eligible charges; lab and x-ray are covered at 80% of eligible charges).
- Infertility treatment exclusions include, but are not limited to:
  - Medical or non-medical costs of anyone not covered under the Plan.
  - Non-medical expenses of a sperm or egg donor covered under the Plan including, but not limited to:
    - Transportation, shipping or mailing, administrative fees such as donor processing, search for a donor or profiling a donor, cost of sperm or egg purchased from a donor bank, cryo-preservation and storage of sperm or embryo, or fees payable to a donor.
  - Infertility treatment deemed experimental in nature.
  - Persons who previously had a voluntary sterilization or persons who are unable to achieve pregnancy after a reversal of a voluntary sterilization.
  - Payment for medical services rendered to a surrogate for purposes of attempting or achieving pregnancy. This exclusion applies whether the surrogate is a plan participant or not.
  - Pre-implantation genetic testing.

Lab and X-ray

- Outpatient:
  - 80% of U&C at a physician's office, hospital, clinic or urgent care center.
- Inpatient:
  - If billed by a hospital as part of a hospital confinement, paid at the appropriate hospital benefit level.

Medical Supplies

- 80% of U&C.
- Medical supplies include, but are not limited to:
  - Ostomy supplies, surgical dressings and surgical stockings.

NOTE: This covers a wide range of supplies for all types of medical conditions. However, the requirement for any supply is that it must have a primary medical purpose.

- Medical supply exclusions include, but are not limited to:
  - Personal convenience items, such as diapers.
  - Supplies that are not medically necessary for the diagnosed illness or injury.
  - Appliances for temporomandibular joint disorder or syndrome (TMJ), myofunctional disorders or other orthodontic therapy.

Newborn Care

- 80% of U&C for professional visits in the hospital:
  - Facility charges paid at appropriate benefit level, see Inpatient Hospitalization.
- Benefits are available for newborn care only if the dependent is enrolled no later than 31 days following the birth.

Nurse Practitioner

- 80% of U&C for professional services provided under the supervision of a physician and billed by a physician, hospital, clinic or home health care agency.

Occupational Therapy/Physical Therapy

- 80% of U&C, if administered under the supervision of and billed by a licensed or registered occupational therapist, physical therapist or physician.
- Eligible charges for medically necessary therapeutic modalities for acute illness or injury are covered. Coverage ends once medical documen-

tation indicates the maximum medical improvement has been achieved and treatment is primarily for maintenance.

- Occupational therapy/physical therapy exclusions include, but are not limited to:
  - Therapy as part of an educational program and considered to be education and/or training.
  - Therapy when improvement is no longer documented.

Physician Services

Effective July 1, 2002, the plan covers 90% of the negotiated fee after the annual plan deductible if utilizing a participating physician in the CIGNA Healthcare PPO Physician Network. U&C does not apply.

- 80% of U&C for non-network providers for medical treatment of an injury or illness.
- Physician charges associated with services not eligible for coverage under the Plan are excluded.
- Inpatient Surgery:
  - Follow-up care by the surgeon is considered part of the cost of the surgical procedure. It is not covered as a separate charge.
- Outpatient Surgery:
  - If surgery is performed in a physician's office, the following will be considered as part of the fee:
    - Surgical tray and supplies.
    - Local anesthesia administered by the physician.
    - Medically necessary follow-up visits.
- Plastic Surgery is limited to the following:
  - An accidental injury.
  - Congenital deformities that are evident in infancy.
  - Reconstructive mammoplasty following a mastectomy when medically indicated.
- Assistant surgeon:
  - A payable assistant surgeon is a physician who assists the surgeon subject to medical necessity.
  - Up to 20% of U&C of eligible charges.
- Multiple procedures:
  - Standard guidelines are used in processing claims when multiple surgical procedures are performed during the same operative session.
  - Benefits will be paid for the most inclusive (comprehensive) procedure. Additional procedures are paid at a lesser level. Contact the Medical Plan Administrator for a pre-determination of benefits.
- Surgical exclusions include, but are not limited to:
  - Abortion, induced miscarriage or induced premature birth, unless it is a physician's opinion that such procedures are necessary to preserve the life of the mother, or an induced premature birth is intended to produce a live, viable child and is necessary for the health of the mother or her unborn child.
  - Keratotomy or other refractive surgeries.
  - Obesity surgery unless medically necessary to treat morbid obesity (two times normal body weight).
  - Surgery not recommended, approved and performed by a physician.

Podiatry Services

- 80% of U&C for medically necessary podiatric treatment and surgeries.
- Routine foot care is covered only with the diagnosis of diabetes.

Prescription Drugs

- 80% of U&C if the drug is billed by a physician's office and not obtained at a pharmacy.
- Prescription drugs obtained as part of a hospital stay, skilled nursing facility, extended care facility or a nursing home are payable at the appropriate facility benefit level.
- If purchased at a pharmacy, the Prescription Drug Plan benefits apply.

See Chapter 2, Section entitled Prescription Drug Plan.

Prosthetic Appliances

A prosthetic appliance is one which replaces a body part. Examples are artificial limbs and artificial eyes.

- 80% of U&C for:
  - The original prosthetic appliance.
  - Replacement of a prosthetic appliance due to growth or a change in the person's medical condition.

- Repair of a prosthetic appliance due to normal wear and usage and no longer functional.

- No payment will be made if the appliance is damaged or lost due to negligence.
- Prosthetic appliances exclusions include, but are not limited to:
  - Appliances not recommended or approved by a physician.
  - Appliances to overcome sexual dysfunction, except when the dysfunction is related to an injury or illness.
  - Items considered to be cosmetic in nature such as artificial fingernails, toenails, eyelashes, wigs, toupees or breast implants.
  - Experimental or investigational appliances.
  - Hearing aids or dentures.

Radiation Therapy

- 80% of U&C for radiation therapy ordered by a physician in an outpatient setting.
- Appropriate facility benefit for inpatient stays.

Second Surgical Opinion

The Notification Administrator will determine the necessity of obtaining a second opinion for both inpatient and outpatient procedures.

- 100% of U&C if required by Notification Administrator. No plan year deductible applies.
  - Contact the Notification Administrator who will determine if a second opinion for a surgical procedure is required.
  - Failure to obtain a second opinion when required and proceeding with the surgery will result in a $1000 penalty.
- 80% of U&C (if not required by the Notification Administrator). Plan year deductible applies.

Skilled Nursing –
In a Home Setting

- Contact the MCM Administrator for a determination of maximum benefits.
- 80% of eligible charges.
- The benefit for skilled nursing care will be limited to the lesser of the cost for care in a home setting or the average cost in a skilled nursing facility, extended care facility or nursing home.
- The continued coverage for skilled nursing care will be determined by the review of medical records and nursing notes.

Skilled Nursing –
In a Skilled Nursing Facility, Extended Care Facility or Nursing Home

- Must be a licensed healthcare facility primarily engaged in providing skilled care.
- Notification is required at least 7 days prior to admission or at time of transfer from an inpatient hospital stay.
- 80% of U&C for eligible charges.
- The service must be medically necessary and ordered by a physician.
- The continued coverage for skilled nursing care will be determined by the review of medical records and nursing notes.
- Holding charges (charges for days when the bed is not occupied by the patient) are not covered.
- Benefits are available up to 100 days each plan year. Benefits cease after the 100th day.

NOTE: Extended care facilities are sometimes referred to as nursing homes. Most care in nursing homes is NOT skilled care and therefore is NOT covered. Many people purchase long-term care insurance policies to cover those nursing home services which are NOT covered by medical insurance or Medicare.

Speech Therapy

- 80% of U&C for medically necessary speech therapy ordered by a physician.
- Treatment must be for a speech disorder resulting from injury or illness serious enough to significantly interfere with the ability to communicate at the appropriate age level.
- The therapy must be restorative in nature; with the ability to improve communication.
- The person must have the potential for communication.

Transplant - Organ and Tissue

(Notification Required)

TCHP includes a Transplant Preferred Provider Organization (TPPO) hospital network. **For organ or bone marrow transplants to be covered under the Plan, one of the designated organ-specific TPPO hospitals must be utilized.** The network is subject to change. Call the Notification Administrator for information on current TPPOs.

- The transplant process has three phases:

1. **Pre-transplant Evaluation Phase:**

   All diagnostic treatment rendered to determine if a plan participant may be a candidate for a transplant is paid at normal plan benefits.

   The transplant candidate must contact the Notification Administrator of the potential transplant. Once notification occurs, the Medical Case Management (MCM) Administrator will coordinate all additional treatments and services. Benefits are limited to services approved by the Notification Administrator. There may be no benefits available for charges related to listing with multiple hospitals, duplicate or repetitive services.

   This phase consists of transplant-related services necessary to assess and evaluate the transplant candidate. If the transplant candidate receives services during this phase in a TPPO, benefits are payable at 80% of the contracted rate.

2. **Transplantation and Hospitalization Phase:**

   This phase begins on the first day of the transplant inpatient stay and continues through the day of discharge. For transplants performed in an outpatient setting this phase begins on the date of the transplant procedure. Benefits are paid at 80% after a $100 transplant deductible.

3. **Post-Transplant Phase:**

   This phase begins immediately following inpatient or outpatient discharge and continues for 12 months. All charges submitted by the TPPO are covered at 80% of the contracted rate. All other services are subject to normal plan provisions.

- Benefits are available for the following transplants:
  - Bone Marrow (autologous or allogenic)
  - Heart
  - Heart/Lung
  - Kidney
  - Kidney/Pancreas
  - Liver
  - Lung
  - Pancreas

In some cases, transplants may be considered non-viable for some candidates, as determined by the Notification Administrator in coordination with the transplant hospital.

- Transplant exclusions include, but are not limited to:
  - Investigational drugs or experimental procedures.
  - Charges related to the search for an unrelated bone marrow donor.
  - Corneal transplants.

NOTE: If a physician determines that a plan participant is being considered for a transplant, the Notification Administrator must be contacted within two business days. The Notification Administrator will assist in maximizing benefits and ensuring services are covered.

Coordination of Benefits

- When both donor and recipient are covered under the Plan, both are entitled to benefits under the Plan, under separate claims.
- When only the recipient is covered, the donor's charges are covered as part of the recipient's claim, if the donor does not have insurance coverage, or if the donor's insurance denies coverage for medical expenses incurred.
- When only the recipient is covered by the Plan, and the donor's insurance provides coverage, the Plan will coordinate with the donor's plan.
- When only the donor is covered, only the donor's charges will be covered under the Plan.

Transportation and Lodging Benefit

- The Plan will also cover transportation and lodging expenses for the patient and one immediate family member or support person prior to the transplant and for up to one year following the transplant. This benefit is available only to those plan participants who have been accepted as a candidate for transplant services in a program.
  - The maximum expense reimbursement is $2,400 per case. Automobile mileage reimbursement is limited to the mileage reimbursement schedule established by the Governor's Travel Control Board. Lodging per diem is limited to $70. There is no reimbursement for meals.

Requests for reimbursement for transportation and lodging with accompanying receipts should be forwarded to:

CMS/Group Insurance Division
Attn: Organ Transplant Reimbursement
Room 600, Stratton Office Building
Springfield, IL 62706

Urgent Care Services

Urgent Care is care for an unexpected illness or injury that requires prompt attention, but is less serious than emergency care. Treatment may be rendered in facilities such as a physician's office, urgent care facility or prompt care facility. Medically necessary emergency care is considered at 100% of U&C (see Emergency Services in this section).

- 80% of U&C for non-emergency care.

NOTE: See Emergency Services for medically necessary emergency care.

For information regarding these or other covered benefits contact the Medical Plan Administrator.

TCHP – PREVENTIVE SERVICES

Overview

Routine services which do not require a diagnosis or treatment are often referred to as preventive services. There are limitations on the frequency and coverage for some preventive services.

Unless otherwise noted, preventive services are **not** subject to the plan year deductible. Claims which indicate a diagnosis are not considered preventive and are subject to the plan year deductible.

Only the preventive services listed below are covered under TCHP.

Covered Benefits –

- **Colorectal Cancer Screening:**
  - 80% of U&C for sigmoidoscopy once every 3 years for persons who are at least 50 years old.
  - 80% of U&C for sigmoidoscopy once every 3 years for persons who are at least 30 years old and have a family history of colorectal cancer.
  - 100% of U&C for fecal occult blood testing once every 3 years for persons who are at least 50 years old or for persons at least 30 years old who have a family history of colorectal cancer.
  - 80% of U&C for professional charges associated with the interpretation of the screening.
- **Mammography:**
  - 100% of U&C for one baseline mammogram for women age 30-39.
  - 100% of U&C for one mammogram per plan year for women age 40 and over.
  - 80% of U&C for professional charges associated with the interpretation of the test.
- **Pap/Cervical Smears:**
  - 100% of U&C for pap/cervical smear once per plan year.
  - 80% of U&C for office visit.
  - 80% of U&C for professional charges associated with the interpretation of the test.
- **Prostate Screening:**
  - 100% of U&C for prostate-specific antigen test for men age 40 and over once per plan year.
  - 80% of U&C for office visit for prostate exam.
  - 80% of U&C for professional charges associated with the interpretation of the screening.

TCHP – PRESCRIPTION DRUG PLAN

Overview

Prescription drug benefits are independent of other medical services and are not subject to the plan year deductible or the medical out-of-pocket maximums. The Prescription Drug Plan includes both in-network and out-of-network benefits.

Most drugs purchased with a prescription from a physician or dentist are covered. Drugs that can be lawfully purchased without a prescription are not covered, except insulin. No over-the-counter drugs will be covered even if purchased with a prescription.

Diabetic supplies and insulin are covered through the Prescription Drug Plan. In order for insulin and diabetic supplies to be a covered benefit under this Plan, they must be purchased **with** a prescription. Diabetic supplies are subject to the appropriate brand copayment.

Some diabetic supplies are also covered under Medicare. If the plan participant is not Medicare primary, the appropriate copayment must be paid at the time of purchase at network pharmacies. If Medicare Part B is primary, the plan participant is responsible for payment at the time of purchase. The claim must first be submitted to Medicare for reimbursement. Upon receipt of the Medicare Explanation of Benefits, a claim may be filed with the Prescription Drug Plan Administrator for any secondary benefit due from this Plan.

A Preferred Drug List (formulary) is a list of prescription medications that have been chosen because of their ability to be both clinically and cost effective. The drugs selected for the Preferred Drug List have been carefully reviewed by a team of medical professionals and must meet high standards for quality and effectiveness. Utilizing the Preferred Drug List helps control plan costs and ensure a quality drug plan for all plan participants. For specific information regarding the Preferred Drug List and the appeal process, contact the Prescription Drug Plan Administrator.

The prior authorization program is designed to manage the use of a select list of medications that have the potential for being prescribed for unapproved uses, improper dosage or exceeds the recommended drug therapy guidelines. If a prescription is presented for one of these medications, the pharmacist will indicate that a prior authorization is needed before the prescription can be filled. To receive a prior authorization the prescribing physician must provide a written diagnosis to the Prescription Drug Plan Administrator for review. Once a prior authorization is in place, the prescriptions may be filled until the authorization expires, usually one year.

In-Network Benefits

The Pharmacy Network consists primarily of retail pharmacies which accept the copayment and electronically transmit the prescription claim for processing.

There are over 55,000 pharmacies in the network nationwide, including independent community pharmacies and all major chains.

For the most up-to-date information on network pharmacies call the Prescription Drug Plan Administrator in Chapter 3, Section entitled Plan Administrators.

- **In-Network Benefit Summary:**
  - No plan year deductibles; no claim forms to file.
  - Flat Copayments (1 to 30-day supply):
    - Generic $ 7.00
    - Preferred Brand $14.00
    - Non-Preferred Brand $28.00
  - When the pharmacy dispenses a brand drug for any reason, and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment of $7.00.
  - If only a brand drug is available, the copayment will be $14.00 or $28.00.
  - When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.
  - The maximum days' supply available at one retail pharmacy fill is 60 days. The copayments described above will **double** for any prescription **exceeding 30 days.**

Mail Service Program

Beginning July 1, 2002 maintenance medications will be available through mail order at the following copayments:

- Flat Copayments (90-day supply):
  - Generic $14.00
  - Formulary Brand $28.00
  - Non-Formulary Brand $56.00

The Mail Service Program provides a convenient and cost-effective way for you to order a 90-day supply of "maintenance" or long term medication for direct delivery to your home. Each plan year, plan participants may be required to obtain a new prescription from their physician for the Mail Service Program.

Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Plan participants must pay all charges at the time of purchase and file a paper claim form with the Prescription Drug Plan Administrator. Reimbursement will be at the applicable brand or generic network price minus the appropriate copayment described above. **In most cases, the cost of the prescription drugs will be higher when not using network pharmacies.** Claim forms are available from the Prescription Drug Plan Administrator.

Exclusions

The Program reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

TCHP – MENTAL HEALTH/SUBSTANCE ABUSE

Overview

Mental health/substance abuse treatment is offered through the Member Assistance Program (MAP). For questions concerning notification and authorization of services contact the MAP Administrator listed in Chapter 3, Section entitled Plan Administrators.

Eligible benefits for mental health/substance abuse services are not subject to the annual medical plan deductible or the out-of-pocket maximums. Eligible charges are for those services that are deemed to be medically necessary.

Many of the hospital PPO facilities are listed in the annual Benefit Choice Options Booklet. Contact MAP to verify additional participating facilities.

In an emergency or a life-threatening situation, call 911, or go to the nearest hospital emergency room. Call MAP as soon as possible, but within 48 hours to avoid a $1,000 penalty and all costs for services not authorized.

Notification and Authorization Requirements

Notification is the initial telephone call to MAP which begins the authorization process. Notification to MAP is required for services at all levels of care to authorize care and avoid penalties.

A MAP licensed behavioral health professional will conduct a review to determine if treatment meets medical necessity criteria and appropriateness of care. If treatment meets medical necessity criteria service will be authorized and eligible for benefit coverage. Contact MAP with questions about whether all or any part of a service will be covered.

- **Inpatient services** must be authorized by MAP prior to admission or within 48 hours of an emergency admission. Notification and authorization are required with each new admission. Failure to notify MAP of an admission to an inpatient facility within the time limits will result in a $1,000 penalty. No benefits are reimbursable for services that are not authorized.
- **Alternative treatment programs (partial hospitalization and intensive outpatient treatment)** must be authorized by MAP prior to admission. Notification is required before beginning each treatment program. Failure to notify MAP of an alternative treatment program will result in a $1,000 penalty. No benefits are reimbursable for services that are not authorized.
- **Outpatient services** are authorized by calling MAP for a referral to an in-network provider. Medically necessary outpatient services received without a referral and authorization will be subject to the standard benefit (out-of-network).
- **Psychological testing** must be authorized to receive an in-network or out-of-network benefit.
- **Coordination of Benefits (COB)** - Plan participants, who are entitled to benefits under another group health plan, must notify MAP so that medical necessity can be determined, authorization can be given and benefits applied accordingly.

Medicare COB

- **Medicare Part A – Hospital Insurance**

  After Medicare Part A pays, MAP pays:

  – All but $50 of the Medicare Part A deductible.

  – Plan participant's coinsurance.

- **Medicare Part B – Medical Insurance:**

  Medicare Part B primary plan participants should always contact Medicare for a list of Medicare-approved providers.

  Plan participants who receive services from a provider who is not Medicare-approved must notify MAP to receive authorization for enhanced benefits (in-network).

  If the provider is Medicare-approved and accepts assignment, Medicare pays 50% of the Medicare-approved amount and MAP pays:

  – Any part of the annual deductible for which the plan participant is responsible at that time.

  – The plan participant's coinsurance.

  If the provider is Medicare-approved, but does not accept assignment, Medicare pays 50% of the approved amount and MAP pays:

  – Any part of the annual deductible for which the plan participant is responsible at that time.

  – The plan participant's coinsurance and all amounts Medicare does not cover, up to the maximum limiting charges set by Medicare.

- If the provider is not Medicare-approved, Medicare pays 0% and MAP pays:

  – 50% up to $35 for outpatient visits with a maximum of 50 visits per plan year for visits not authorized by MAP, or

- 100% after a $15 copayment for visits authorized by MAP.

NOTE: Retired plan participants who are eligible for premium-free Medicare Part A must enroll in Medicare Part B to avoid reduction in benefits by the amount that Medicare Part B would have paid.

Out-of-Area Benefits

If plan participants do *not* live within 25 miles of a TCHP PPO facility for inpatient or an alternative level of treatment, the following benefits apply:

- **Outpatient**

  Applicable enhanced or standard benefits as listed in the Mental Health/Substance Abuse Benefit Summary Chart on the following page.

- **Inpatient**
  - $50 per day copayment, up to a maximum of $250 per admission.
  - 80% coverage of additional facility charges.
  - Professional charges are reimbursed at the applicable enhanced or standard benefit level.
  - Maximum out-of-pocket is $1,500 per plan year.
- **Alternative Treatment**
  - $25 per day copay, up to a maximum of $125 per admission.
  - 80% coverage of additional facility charges.
  - Professional charges are reimbursed at the applicable enhanced or standard benefit level.
  - Maximum out-of-pocket is $1,500 per plan year.

Mental Health/Substance Abuse Benefit Summary

All mental health and substance abuse services are subject to medical necessity. Services that are determined not medically necessary will not be reimbursed.		
	Enhanced Benefit (In-Network)	**Standard Benefit (Out-of-Network)**
Outpatient	100% coverage after $15 copayment per visit	50% coverage up to $35 per visit* 50 visits maximum per plan year
Inpatient	$50 per day copayment, up to a maximum of $275 per admission for facility charges 100% coverage of additional facility charges 100% coverage of professional charges, after the $15 copayment**	$50 per day copayment, up to a maximum of $250 per admission for facility charges 60% coverage of additional facility charges 50% coverage of professional charges up to $35 per visit*; 50 visits maximum per plan year
Alternative Treatment (Partial Hospitalization Intensive Outpatient)	$25 per day copayment, up to a maximum of $125 per admission for facility charges 100% coverage of additional facility charges 100% coverage of professional charges after the $15 copayment**	$25 per day copayment, up to a maximum of $125 per admission for facility charges 60% coverage of additional facility charges 50% coverage of professional charges up to $35 per visit*; 50 visits maximum per plan year

* All outpatient services received at the standard benefit level must be provided by a licensed clinical social worker (LCSW), licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), licensed psychologist (Ph.D.) or licensed psychiatrist (M.D.) to be eligible for coverage.

** Standard benefit for professional charges are covered at 50% up to $35 per day. 50 visits maximum per plan year.

TCHP – EXCLUSIONS

Health Plan Exclusions

No benefits are available:

1. For services or care not recommended, approved and provided by a person who is licensed under the Illinois Medical Practices Act or other similar laws of Illinois, other states, countries or by a Nurse Midwife who has completed an organized program of study recognized by the American College of Nurse-Midwives or by a Christian Science Practitioner.
2. For services and supplies not related to the care and treatment of an injury or illness, unless specifically stated in this Handbook to be a covered service in effect at the time the service was rendered. Services and supplies that are excluded include, but are not limited to: sports-related health check-ups, employer-required check-ups, wigs and hairpieces.
3. For care, treatment, services or supplies which are not medically necessary for the diagnosed injury or illness, or for any charges for care, treatment, services or supplies which are deemed unreasonable.
4. For charges for services, room and board or supplies that exceed U&C.
5. For personal convenience items, including but not limited to: telephone charges, television rental, guest meals, wheelchair/van lifts, non-hospital type adjustable beds, exercise equipment, special toilet seats, grab bars, ramps or any other services or items determined by the Plan to be for personal convenience.
6. For rest, convalescence, or education, institutional or in-home nursing services which are provided for a person due to age, mental or physical condition mainly to aid the person in daily living such as home delivered meals, child care, transportation or homemaker services.
7. For extended care and/or hospital room and board charges for days when the bed has not been occupied by the covered person (holding charges).
8. For private room charges in excess of the established semi-private room and board charges, regardless of any medical necessity such as isolation.
9. For routine foot care, including removal in whole or in part of corns, calluses, hyperplasia hypertrophy and the cutting, trimming or partial removal of toenails, except for patients with the diagnosis of diabetes.
10. For chiropractic services, occupational therapy and physical therapy considered to be maintenance in nature, in that medical documentation indicates that maximum medical improvement has been achieved.
11. For keratotomy or other refractive surgeries.
12. For the diagnosis or treatment of obesity, except when certified by a physician as morbid obesity (two times normal body weight).
13. For sexual dysfunction, including prescriptions, except when related to an injury or illness.
14. For services relating to the diagnosis, treatment and/or appliance for temporomandibular joint disorders or syndromes (TMJ) myofunctional disorders or other orthodontic therapy.
15. For the expense of obtaining an abortion, induced miscarriage or induced premature birth, unless in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except in an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child.
16. For cosmetic surgery, except for the repair of accidental injury, for congenital deformities evident in infancy or for reconstructive mammoplasty after partial or total mastectomy when medically indicated.
17. For services rendered by a health care provider specializing in the mental health care field who is a psychoanalytic candidate in training.
18. For services and supplies which do not meet accepted standards of medical or dental practice at the time the services are rendered.
19. For services which are investigational or experimental in nature, including procedures and/or services performed in special settings for research purposes or in a controlled environment and are being studied for safety, efficacy and effectiveness and awaiting endorsement by the appropriate national medical specialty college for general use within the medical community.
20. For the purchase of the first three pints of blood or blood plasma.
21. For services due to bodily injury or illness arising out of or in the course of a plan participant's employment, which is compensable under any Workers' Compensation or Occupational Disease Act or law.

22. For court mandated services, if not a covered service under this Plan or not considered to be medically necessary by the TCHP Administrator.
23. For services or supplies for which a charge would not have been made in the absence of coverage or for services or supplies for which a plan participant is not required to pay.
24. For services arising out of war or an act of war, declared or undeclared, or from participation in a riot, or incurred during or as a result of a plan participant's commission or attempted commission of a felony.
25. For services related to the reversal of sterilization.
26. For lenses (eye glasses or contacts) except initial pair following cataract surgery.
27. For expenses associated with obtaining, copying or completing any medical or dental reports.
28. For services rendered while confined within any federal hospital, except for charges a covered person is legally required to pay, without regard to existing coverage.
29. For charges imposed by immediate relatives of the patient or members of the plan participant's household as defined by the Centers for Medicare and Medicaid Services.
30. For services rendered prior to the effective date of coverage under the Plan or subsequent to the date coverage is terminated.
31. For hearing aids and associated costs including the exam and evaluation for the purpose of screening and obtaining a hearing aid, regardless of diagnosis.
32. For private duty nursing, skilled or unskilled, in a hospital or facility where nursing services are normally provided by staff.
33. For services or care provided by an employer sponsored health clinic or program.
34. For routine physical exams, immunizations, flu shots, acupuncture and smoking cessation programs.
35. For treatment of teeth or periodontium unless such expenses are incurred for:
    a) charges made for a continuous course of dental treatment started within 3 months of an injury to sound natural teeth caused by an external force;
    b) charges for inpatient room and board determined to be medically necessary by the Notification Administrator.

TCHP – CLAIM FILING DEADLINES AND PROCEDURES

These procedures and deadlines pertain to the TCHP medical, Prescription Drug Plan and Mental Health/ Substance Abuse Plan. Utilization of pharmacy and Mental Health/Substance Abuse network providers eliminates the need to file paper claims. However, if an out-of-network provider is utilized the procedures and deadlines must be followed.

Contact the appropriate plan administrator with any questions about covered services, benefit levels or claim payments.

Claim Filing Deadlines

- **All claims should be filed promptly. The Plans require that all claims be filed no later than:**

– One year from the ending date of the plan year in which the charge was incurred for claims with dates of service on or after July 1, 2001.

Claims with Service Dates of:	Final Filing Date
July 1, 2000 thru June 30, 2001	No longer eligible
July 1, 2001 thru June 30, 2002	June 30, 2003
July 1, 2002 thru June 30, 2003	June 30, 2004
July 1, 2003 thru June 30, 2004	June 30, 2005
July 1, 2004 thru June 30, 2005	June 30, 2006
July 1, 2005 thru June 30, 2006	June 30, 2007

Claim Filing Procedures

All communication to the plan administrators must include the Benefit Recipient's Social Security number (SSN) and appropriate Group Number as listed on the identification card. This information must be included on every page of correspondence.

- Complete the claim form obtained from the appropriate plan administrator.
- Attach the itemized bill from the provider of services to the claim form. The itemized bill must include name of patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.
- If the person for whom the claim is being submitted has primary coverage under another group plan or Medicare, the Explanation of Benefit (EOB) from the other plan must also be attached to the claim.
- The plan administrators may communicate directly with the plan participant or the provider of services regarding any additional information that may be needed to process a claim.
- The benefit check will be sent and made payable to the Benefit Recipient (not to any dependents), unless benefits have been assigned directly to the provider of service.
- If benefits are assigned, the benefit check is made payable to the provider of service and mailed directly to the provider. An EOB is sent to the plan participant to verify the benefit determination.
- Utilization of pharmacy network providers generally eliminates the need to file paper claims when receiving prescription drugs. When a prescription drug is purchased from a non-network pharmacy, a paper claim must be submitted to the prescription drug plan administrator for claim payment. If Medicare is primary, see Prescription Drug Plan on page 49 of this Handbook for coverage information.

Benefits for Services Received While Outside The United States

The Plans cover eligible charges incurred outside of the country for generally accepted medically necessary services usually rendered within the United States.

All plan benefits are subject to plan provisions and deductibles. The benefit for facility charges is 70% of U&C and professional charges are paid at 80% of U&C. Notification is not required outside of the United States.

Payment for the services will most likely be required at the time of services. File a claim for reimbursement with the Medical Plan Administrator. When filing a claim, enclose the itemized bill with a description of the services translated to English and the dollar amount converted to U.S. currency, along with the name of the patient, date of service, diagnosis, procedure code and the provider's name, address and telephone number.

In general, Medicare will not pay for health care obtained outside the United States and its territories. If Medicare is primary, include the Explanation of Medicare Benefits (EOMB) denying payment, along with the claim form and send to the Medical Plan Administrator.